AccuReview

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[Date notice sent to all parties]: January 7, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board certified in Anesthesiologist with over 15 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XX: Initial Examination dictated by XX. CC: XX. XX XX pain with radiating symptoms on the XX leg. XX reported that XX XX on XX while XX was doing a XX. XX also sustained a XX tear from that accident. Claimant attended PT at another facility for XX shoulder. XX related that XX first got a XX injection in XX XX and then had an unknown procedure and is scheduled ot have another procedure on XX to address XX XX symptoms. Recommended treatments: XX, manual therapy, XX, XX laser, Therapeutic exercises and activities, XX training, Posture/biometric instruction, work/ergonomic assessment, taping/strapping, XX. Assessment/Diagnosis: Claimant with XX XX pain s/p XX on XX. Upon evaluation, XX demonstrated painful and limited XX XX, decreased XX XX strength, poor XX balance XX, and reports limited XX and XX tolerance. XX is s/p XX XX repair on XX and wears a XX XX XX XX. Claimant would benefit from skilled therapy to address the impairments. Prognosis for improvement is good within the limitation of the underlying diagnosis. Skilled PT recommended XX/week for XX weeks, and then reassess, to allow him to have improved activity tolerance with less XX pain. However, claimant's shoulder status can limit efficiency of XX rehab. Therefore, it is advised to claimant to contact XX case manager to possibly delay XX XX rehab until after XX finishes with XX shoulder rehab since the claimant

would not be able to perform all exercises and tolerate all positions due to XX shoulder post-surgical precautions.

XX: Recheck Report dictated by XX. Employer: XX. The claimant had a XX to the XX facet as well as XX with no significant improvement. At this point, XX still complains of XX XX pain radiating to the XX XX XX. XX XX is pending on XX. XX has had a XX evaluation for chronic pain program. PE: Toe and heal walking is XX on the XX. XX is positive on the XX. Decreased XX sensation in the XX XX. The MRI showed XX lateral XX with encroachment on XX. Therefore, I would like to do a XX XX diagnostic XX as XX still complains of pain and wished to get a XX evaluation. Follow up in the clinic in one month.

XX: Office Visit dictated by XX. CC: XX. DX: XX, initial encounter XX. Procedure: XX.

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XX: Progress Note dictated by XX. S/P XX radiofrequency XX on XX and XX shoulder surgery on XX. Still complaining of XX after XX XX. XX is not on PT as prescribed by ODG. Claimant still has significant XX and the difference is in the distance of walking. Assessment: XX sprain/strain. Plan: Claimant needs to get PT as per ODG after XX XX of the XX facet. XX in one month.

XX: Progress Note dictated by XX. Claimant has XX that is very localized and not improving by XX or any other maneuvers. XX stated that XX pain in the XX is improved. XX has not had PT by the ODG. On PE, XX has some XX in the XX XX aspect along the XX. Assessment: XX sprain and strain. The claimant needs to get PT as per ODG after XX XX of the XX XX. We will ask for XX patch for XX XX XX thigh. XX also has XX. We will ask for a XX XX. F/U one month.

XX: Office Visit dictated by XX. CC: XX XX pain, XX XX. DX: XX, unspecified XX limb XX. XX performed.

XX: Progress Note dictated by XX. Looking to get the claimant into XX. XX is unchanged. Will order XX which is pending and refer to XX surgeon for evaluation as claimant requested.

XX: XX performed by XX. Reason for denial: Prior treatment included injections, medications, and PT. The claimant was diagnosed with XX without XX or XX, XX region. Per ODG, xx are recommended only for XX that is XX Review of records indicated an absence of evidence of XX prior to October 2018. There is no record of a trail of conservative therapy since new onset of XX. Furthermore, XX MRI findings are documented in in enough detail to corroborate XX. The original MRI report was not submitted for review. There fore the request is not medically necessary.

XX: Office Visit dictated by XX. CC: XX that radiates into the XX XX extremity. DX: XX, initial encounter. Plan: XX on the XX.

XX: XX performed by XX. Reason for denial: The appeal request for XX is not medically necessary. MRI showed no evidence of any XX or XX nor is there an XX XX confirm XX to support the injection. The XX noted the claimant had new XX findings as of the XX visit yet there has not been any attempt to address this with conservative therapy before requesting and XX. Therefore, the appeal request is not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld and agreed upon. Based on the records submitted, and peer reviewed guidelines, this request is non-certified. The appeal request for XX is not medically necessary. MRI showed no evidence of any XX or XX nor is there an XX to confirm XX to support the injection. The XX noted the claimant had new XX findings as of the XX visit yet there has not been any attempt to address this with conservative therapy before requesting and XX. According to the ODG XX Back guidelines, there must be documented XX and demonstrated failure of conservative therapy in order to create medical necessity for an XX request. Therefore, the appeal request for XX XX is not medically necessary and denied.

	XX

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**